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As noted at 7.2, it is not possible to distinguish between the influence of maternal smoking during pregnancy and that of exposure of their children to ETS after birth. Taylor and Wadsworth (Tay87) found that only maternal smoking during pregnancy influenced the risk of hospitalization for respiratory infections in children under the age of five. In children whose mothers did not begin smoking until after the pregnancy the risk was no greater than in children of non-smoking mothers. A link was found between bronchitis reported by parents and maternal smoking after the pregnancy, but it was less strong than the link with smoking during pregnancy. In a large-scale study in the Chang-Ning district of China an increased risk of respiratory infections in children was also found where only the father smoked. Closer analysis of the data from this study also shows that the effect of exposure to ETS on the number of hospitalizations for respiratory disorders is greater in bottle-fed than in breast-fed young children (Che89). A link between parental smoking and the occurrence of respiratory complaints was also found in a study of schoolchildren in the Netherlands. After correction for smoking during pregnancy the influence of parental smoking was found to be smaller, but the link remained statistically significant (Dij89).

In several of the studies mentioned the link between parental smoking and respiratory infections and complaints in the children diminished once the figures had been corrected for respiratory complaints in the parents. In most cases, however, it remained statistically significant (Leb76, War84, Fer85a, Som88, Dij89). This shows that the increase found in the risk of respiratory disorders (or symptoms) was not caused exclusively by contact with parents who smoked and were susceptible to infections (selection bias) or "overreporting" of symptoms in children of parents who smoked (information bias).

As noted at 7.2, smoking by older children may have caused distortion of the results. Even allowing for this, the link between parents who smoked and respiratory complaints in children remained statistically significant in most cases (Bla78, Wei80, Dod, Sch83, Cha84, Bur86, Tag86, Som88).

Recent research in particular has made sufficient allowance for known confounders such as the socio-economic status of the family, the number of persons per household and other sources of indoor air pollution.

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Respiratory infections and complaints constitute a serious inconvenience to children, possibly resulting in absence from school and the need for medical treatment. There are indications that respiratory infections in the first years of life can increase the risk of chronic obstructive respiratory disorders in later life (Col73, Bur77, Sam83, Bar86, Bri87).

The long-term significance of respiratory disorders is not yet clear. Schrader found a strong link between the occurrence of respiratory complaints before puberty and during adolescence. He also found that their occurrence before

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puberty, at least in boys, was linked to a slight reduction in pulmonary function during adolescence, even where the complaints had already disappeared (Sch88). Studies of large cohorts also yielded indications that respiratory complaints during childhood were linked to a more rapid reduction in pulmonary function and the occurrence of chronic obstructive lung disease in later life (Col73, Fle76, Bur77, Sam83, Len86, Sam87). It is not clear to what extent this is a causal connection.

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7.3.2 Effects on the development of pulmonary function

The results of cross-sectional studies show that the FEV1 and MMEF (see 7.3, Introduction) of children of parents who smoke is slightly reduced, compared with children of non-smoking parents (USS86, Tag79, Wei80, Che86, Dij89). Prospective cohort studies have subsequently confirmed that exposure to ETS affects the development of pulmonary function (Tag83, War84, Bur86, Ber86, Ste87). Pulmonary function declines the more smoking takes place in the home. The smoking of both parents is influential, especially the mother (Kau89a, Che88). The effect of ETS seems to be greatest in younger children.

Tager et al. found that exposure to ETS had an effect on children living in Boston but not on children living in Tucson. Their supposition was that children living in a hot, dry climate are less exposed in the home (Tag87).

As noted at 7.2, the effect on pulmonary function in children of mothers who smoke could be linked to exposure in the uterus, as well as to ETS (Yar79, Ste87). Reduced pulmonary function was also found in young children of mothers who had not smoked during pregnancy, in research by Houthuijs et al. (1987) and Dijkstra et al. (1989). The Chang-Ning study mentioned above demonstrated an effect on pulmonary function of children whose fathers alone smoked (Che88). The reduction in pulmonary function is thus not only the result of exposure in the uterus.

The reduction in pulmonary function found in children of parents who smoke is of the order of one to five percent on average. A reduction of this magnitude does not as a rule constitue a substantial impediment to the normal functioning of children.

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7.3.3 Sensitivity of the respiratory tract

Asthma is characterized by hyperreactivity of the bronchial tubes, causing them to narrow in reaction to various stimuli. Most of the epidemiological studies showed that asthma symptoms are more common or more serious in children of parents who smoke than in children of non-smoking parents (Gor82, Ekw83, Eva87, McC85, 86, Bur85, Bur86, Mur86, OCo87, Mur88, Ang89, Mur89). In some studies this link was not found, however (Sch83, Hor85, Tas84, Wei85).

In some studies parental smoking was found to increase the hyperreactivity of the bronchial tubes only in asthmatic children (Mr86, OCo86, Cog87); other researchers also found this effect in non-asthmatic children (Ekw83, Mar88).

Nor were the results of research into the influence of

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exposure to ETS on sensitivity to allergens consistent. No link was found in children between parental smoking and plasma levels of immunoglobulin-E as a yardstick for sensitivity (Own88, Gel87). Other studies, on the other hand, showed a connection between exposure to ETS and positive results of certain skin tests for allergens (Wei85, Mar88).

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7.3.4 Middle ear infections

Case-control and cross-sectional studies show that exposure to ETS is a risk factor for chronic and acute otitis media respectively (Kra85, Bla85, Puk85, Hin88, Hin89, Ive85, Str89). Only the results of Iversen et al. and Strachan et al. were statistically significant. Results of four other cross-sectional studies of middle ear infections did not point to the influence of exposure to ETS (Vin79, Cau84, Bir87, Zie88).

Strachan et al. investigated the occurrence of otitis media in relation to the salivary cotinine level (as an indicator of exposure to ETS). They found a small statistically significant increase in the risk of otitis media on doubling of the cotinine concentration (relative risk: 1.13; 95% CI: 1.00-1.28) (Str89). Use of biological monitoring enabled the dose to be estimated more precisely than in the other studies.

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7.3.5 Absence from school

The results of various studies indicate that children with respiratory symptoms are more often absent from school than other children without such symptoms (see e.g. Hil89). If exposure to ETS causes respiratory disorders there could also be an increase in absence from school, and the results of a couple of studies do in fact point in this direction (Cha89, Ost89).

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7.4 Exposure in the uterus

Maternal smoking during pregnancy influences not only the development of the respiratory tract, it also increases the risk of death before or during birth (Cna88), as well as having an adverse effect on weight and height at birth (Rus89). Hebel et al. found that smoking during pregnancy had no effect on weight and height at birth up to the 4th-6th month but subsequently did have an effect (Heb88).

It could be concluded from the results of a number of studies that maternal smoking during pregnancy also affects motoric and sensory development, ability to concentrate, performance at school and the occurrence of behavioural problems in the child. Since only limited allowance can be made for social, demographic and psychological differences between smokers and non-smokers when analysing research of this kind, it is unclear to what extent exposure in the uterus is a contributory factor (Kri89, Ran83, Rus89).

In four recent epidemiological studies of risk factors a link was found between cot death and maternal (and in some cases also paternal) smoking during pregnancy (Nic89, Kra89, McG89, Hag90).

Other epidemiological studies have yielded indications

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that smoking by the partner of a non-smoking expectant mother can effect the height and weight of the child at birth (Rub86, Mar86, Tri86, Cam88).

Since it is not known to what extent the findings of these studies are distorted, the Committee finds itself at present unable to give a well-considered opinion on whether inhalation of ETS by - non-smoking - expectant mothers is harmful to their unborn children. The Committee would point out that ETS components are able to pass through the placenta (Bot82, Bur82, Etz85, Luc85, Per89). Further research is needed to establish how harmful such indirect exposure is to the unborn child.

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7.5 Conclusions

The Committee concludes that exposure to tobacco smoke in the home can have an adverse effect on the health of children. Children of parents who smoke run an increased risk of respiratory and middle ear infections. They may be more likely to suffer from asthmatic and other respiratory symptoms, and to a more serious extent. The development of the respiratory tract may be affected to a certain extent. Since the occurrence of chronic obstructive lung disorders in later life is linked with respiratory disorders in childhood, the Committee would not rule out the possibility that exposure to tobacco smoke in children could also have a long-term effect, and regards this as an additional reason to limit exposure as far as possible.

In the Committee's opinion there can be no doubt that smoking by expectant mothers is harmful to their unborn children. Children of mothers who smoke have a lower average weight and height at birth, and the risk of perinatal mortality is greater. Although harmful substances in tobacco smoke can pass through the placenta, it is not yet clear what effect it has on the unborn child if a non-smoking mother regularly inhales tobacco smoke during pregnancy.

The Committee's conclusions are in line with those of the National Research Council and Surgeon General in the US (NRC86, USS86) and those of the recent analysis by Spitzer et al. (Spi90).

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8 EFFECTS ON THE RESPIRATORY TRACT IN ADULTS

8.1 Long-term exposure

8.1.1 Results of epidemiological research

The results of research into the influence of long-term exposure to ETS on the occurrence of chronic respiratory complaints in adults (cough, expectoration and wheezing) are contradictory. In cross-sectional studies Schilling et al. and Schenker et al. found that non-smoking spouses of smokers were no more likely to suffer from symptoms of this kind than those of non-smokers (Sch77, Sch83). In a number of case-control and cohort studies such symptoms were found more frequently in non-smokers with housemates who smoked (Kal87, Hol89, Sch90). Kauffmann et al. compared two large cohorts of American and French women respectively. The occurrence of chronic respiratory symptoms was not statistically significantly influenced by exposure to ETS in either study; only in the French women was pulmonary function linked to smoking by housemates (Kau89b).

The results of various studies indicate that ETS can also produce a slight reduction in pulmonary function in adults (measured as MMEF, FEV1; see 7.3, Introduction). In some studies the reduction was statistically significant (Whi80, Kau83, Kau86, Bru85, Hos86, Fis87, Sve87, Mas88, Hol89, Mas90). Cross-sectional studies by Comstock et al. and Kentner et al. and a case-control study by Jones et al. showed no effect from exposure to ETS in the home or at work on the pulmonary function of adults (Com81, Ken84, Jon83).

8.1.2 Significance of the results

It is difficult to draw conclusions from the data mentioned above, since here again the findings may have been distorted in various ways. Potential distorting factors are innaccuracy of exposure variables, selection bias, information bias and disproportionate misclassification of exposure (see Chapter 2).

Throughout their lives adults have been exposed to known and unknown factors which have influenced their pulmonary function to a greater or lesser extent. It is impossible, therefore, to identify the particular contribution made by ETS. The principal confounders in research into pulmonary function and respiratory complaints are exposure at work, other sources of pollution in the home and smoking. The most recent studies try to make allowance for this.

It is not possible to distinguish between the influence

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of exposure to ETS (a) before birth and in childhood and (b) in the adult (Sam83, Mas88).

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8.2 Short-term exposure

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8.2.1 Results of empirical research

Exposure of healthy volunteers to ETS, whether or not during exercise, was found to have virtually no influence on pulmonary function or on the occurrence of respiratory symptoms and subjective complaints (Pim78, She79b, Dah81).

The results of experiments in which asthmatic volunteers were exposed to ETS were inconsistent. In an experiment by Dahms et al. asthmatics reacted much more violently than control subjects to the exposure with a rapid reduction in airway capacity (measured as FEV1) (Dah81). Asthmatic volunteers in the experiment by Shepard et al. (She79), like the healthy volunteers, did not react appreciably to an exposure which was more intense than in Dahms' experiment. In an experiment by Stankus et al. one in three (7 out of 21) of the asthmatic volunteers classified as sensitive to smoke reacted to exposure to ETS with a distinct reduction in airway capacity (Sta88).

In a study by Knight and Breslin exposure to ETS resulted in an increase in the sensitivity of the respiratory tract to histamine (Kni85). Wiedemann et al., on the other hand, using metacholine as the provocative agent, found that exposure to ETS reduced the sensitivity of the respiratory tract (Wie86). Studies by Lehrer et al. and Stankus et al. in which tobacco-specific antibodies (IgE) were measured in, and skin tests carried out on, asthmatic volunteers did not indicate that hypersensitivity to tobacco smoke was based on an allergic reaction (Leb86, Sta88, Har87).

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8.2.2 Significance of the results

The contradictory nature of the results may be connected with the limitations of the studies. Asthmatics are a relatively heterogeneous group, since there are various mechanisms on which their bronchial hyperreactivity may be based. Each of the studies included only a small number of asthmatic volunteers.

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8.3 Conclusions

On the basis of the data available the Committee is unable to make any firm pronouncement on whether long-term exposure to ETS has an adverse effect on the respiratory tract in adults. The effects found in some studies were slight and, in the Committee's opinion, not of any medical significance in healthy subjects. It is not clear to what extent long-term exposure to ETS has an adverse effect on the future health of patients with chronic obstructive respiratory disorders.

In the Committee's opinion there are sufficient indications that asthmatics are often particularly sensitive to exposure to ETS, and ETS is more likely to cause respiratory disorders in these subjects than in others. Further research is needed to establish which types of asthmatics are involved and the size of the hypersensitive

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9 IRRITATION AND NUISANCE

9.1 Introduction

The principal "sensory" effects of exposure to ETS are the perception of odour and irritation of the eyes and mucous membranes of the mouth, nose, throat and lower airways. The irritation is reflected, among other ways, in more frequent blinking, tears, running nose and increased secretion of mucous in the respiratory tract. Whether the odour of ETS and irritation of the mucous membranes are regarded as a nuisance depends not only on the ETS level but also on such things as perception of the health risk, the social circumstances in which the exposure takes place, attitude to smoking and personal smoking habits. A smoky smell in clothes or hair and smoky ceilings, window frames and panes are also mentioned in surveys as annoying consequences of exposure to ETS. Nuisance is difficult to measure objectively. The Committee will therefore confine its considerations to perception of smell and irritation as sensory effects of ETS which can at least to some extent be measured objectively.

Irritation and nuisance are perceived by the senses virtually instantaneously, and consequently even short-term exposure to the peak levels which can occur in the smoke clouds exhaled by smokers is important.

9.2 Smell

The odour of ETS is due primarily to gas-phase components. Habituation causes the degree of odour perception to diminish the longer the exposure lasts. People judge the quality of indoor air mainly by the odour and their perception of the health risks associated with tobacco smoke. Research into the relationship between the amount of ventilation and perception of indoor air quality shows that ETS odour is more likely to be found unacceptable than the body odour perceived when people remain in a closed room. The latter is the criterion upon which recommendations for indoor air quality are customarily based (Cai83, Cai87). ETS odour remains perceptible much longer than body odour (Cla85). Research confirms that non-smokers are more likely to find ETS odour unacceptable than smokers. In practice it is impossible to renew indoor air in such a way as to safeguard all non-smokers from smell with "normal" tobacco consumption indoors (with one in ten persons smoking at any given moment) (Cai83, 87, NRC86).

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9.3 Irritation of eyes, nose, mouth and throat cavities

Caustic chemicals are able to stimulate receptors on the surface of the eye and throughout the mouth, nose and throat cavities and lower airways. Experiments with volunteers which used both subjective (opinions of acceptability) and objective (frequency of blinking, tear fluid production) measures of irritation have yielded a better understanding of the irritating effects of tobacco smoke (Web79, Web80, Mur83a,b, Web84, Win84, Cai87, Cla87).

The degree of irritation depends on the level of tobacco smoke and the duration of exposure. The irritation, like the perception of smell, becomes stronger as the relative humidity of the air falls. The eyes are the most sensitive, followed by the nose. The intensity of the irritation ceases to rise after the first hour of exposure to tobacco smoke.

The irritation is primarily due to the gas-phase components of tobacco smoke. Electrostatic filtering of the dust particles from the smoke has hardly any effect on the irritation to the eyes, nose or throat. Conventional air filters (Cambridge pad) do reduce the irritation. It may be that these filters also trap caustic gas-phase components (Cla85, NRC86).

Experiments in which volunteers were exposed indicate that eye irritation begins to occur at an increase of 1.5-3.0mg/m3 in the level of carbon monoxide (CO) as the ETS indicator (Web84, Mur83a,b). In experiments by Clausen et al. 20 of the 100 exposed subjects suffered from eye irritation at an increase of about 4.6mg/m3 in CO level due to ETS (Cla87). Study of Winneke's sample showed that volunteers exposed under experimental conditions reacted to tobacco smoke stimuli which remained unnoticed in social surroundings. The volunteers they studied in a social setting did not react until an increase in CO level of over 6mg/m3 was reached (Win84). In Weber's sample (Web80, Web79) in restaurants and at 40 workplaces 20 percent of the exposed subjects reported eye irritation at an increase of 2.4mg/m3 in CO level.

There are indications that asthmatics and hay fever sufferers, and even people without symptoms, may be hypersensitive to the irritating effects of ETS on the mucous membranes of the nose, mouth or throat cavity. It is not yet clear whether this hypersensitivity is based on allergy (NRC86). Contact lens wearers may be particularly sensitive to eye irritation.

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9.4 Irritation of the respiratory tract

As reported in previous chapters, acute exposure of healthy children and adults to ETS sometimes resulted in a slight reduction in pulmonary function and symptoms such as cough, expectoration and wheezing. This effect could be due to irritation of the respiratory tract by irritants in ETS. It may be that some asthmatics are hypersensitive to ETS (see Chapter 8).

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9.5 Nuisance

Research shows that perception of air quality depends primarily on smell and to a lesser extent on the irritating

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effect (Cai83, Cai87, Cla87, Web84). The CO levels at which smell is felt to be a nuisance are lower than those at which irritation occurs (Cai87). Research on volunteers exposed to ETS for two hours showed that the amount of fresh air needed to safeguard 80 percent of the subjects present in a room against the irritating effect of tobacco smoke is about a tenth of the amount needed to safeguard the same proportion against smell (12m3 and 120m3 per cigarette respectively for a room of about 30m3) (Cai86, Cla87).

A person entering a room where there is smoking is affected mainly by the smell; people already in the room are affected mainly by the irritating effects (NRC86).

Some studies used questionnaires to examine the contribution made by tobacco smoke to the occurrence of "sick building" complaints such as dizziness, headache, nausea, fatigue and the like. The results were inconsistent (USS86).

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9.6 Conclusions

Smell is the most sensitive measure of nuisance. Non-smokers entering rooms where there is smoking are most affected by the smell. People who stay in such rooms are affected primarily by irritation to the eyes and mucous membranes of the mouth, nose or throat cavity and respiratory tract. The amount of fresh air needed to safeguard them from this is very much greater than that needed to prevent nuisance due to body odour, the criterion upon which ventilation requirements are generally based.

At increasing ETS levels eye irritation occurs first, followed by irritation to the nose, mouth and throat cavities respectively. The Committee concludes from the results of empirical research and field studies that people in rooms where there is smoking begin to suffer from eye irritation when, depending on the circumstances, the carbon monoxide level due to ETS increases by 2.5-6mg/m3.

The Committee is of the opinion that nuisance due to smell and irritation is deleterious to health. Continuous discomfort and the necessity to avoid public places constitute a fundamental assault on a person's well-being. Some sections of the population may be more sensitive to nuisance caused by ETS, e.g. asthmatics, children and adults with a tendency to allergy, and possibly contact lens wearers.

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10 SUMMARY FROM THE HEALTH POINT OF VIEW

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To protect the health of the population the Dutch Government lays down standards for the quality of open air and air at the workplace (Ano89, Ano78). These are based on recommended levels, but non-medical and socio-economic considerations may also play a part. The recommended levels relate to maximum exposure to toxic substances and are scientifically based. A parallel could be drawn with the establishment of these recommendations in the case of tobacco smoke. Over the years criteria have been laid down, e.g. by the Health Council, for the calculation of these levels on the basis of data from animal experiments and clinical and epidemiological research (Gez77, Gez85, Gez88). In line with definitions of health laid down by the Health Council and the World Health Organization, it is not only the onset, aggravation and maintenance of clinical syndromes and shortening of lifespan that are regarded as harmful to health: equally important is the extent to which an exposure effect prevents a person functioning in society, in the opinion of that person, his/her family or medical experts (Gez77). In the Committee's opinion this also applies to the effects of exposure to tobacco smoke.

One criterion is that the recommended levels must also protect sensitive individuals against the adverse effects of substances. The levels consequently include a protection factor related to the lowest level below which no adverse effects are found in epidemiological and clinical research and animal experiments. This margin reflects scientific uncertainties as to the application of data on small homogeneous population samples to the entire heterogeneous population, effects on sensitive individuals in the population which may have been missed, possible interactions with other agents to which people are exposed, and the quality of the available research data (Gez85, WHO87).

A Committee of the Health Council based its recommendations on the criterion that there is no exposure threshold below which carcinogens which attack the genetic material of the cell do not present an increasing cancer risk with increasing doses. It is not possible, therefore, to recommend an absolutely safe level of exposure to these substances (Gez88).

The Committee decided not to compare levels of separate components which can occur indoors as a result of smoking with the recommended levels. The latter apply only to exposure to separate substances, whereas ETS is a complicated mixture

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which enables all sorts of interactions to take place between substances. There are other objections too. The recommended level for respirable dust, which could be exceeded as a result of smoking indoors, is based on the effect of dust as a pollutant in open air. The composition of the latter dust, however, differs considerably from that of dust in ETS. A similar argument also applies to e.g. polycyclic aromatic hydrocarbons.

As already indicated, the Committee is of the opinion that the criteria for the calculation of recommended levels do apply to the medical assessment of exposure to ETS, in particular the definition of "harmful effects on health", and to the aim of also protecting sensitive individuals. On this basis the Committee takes the view that short-term exposure to ETS is harmful to health. Regularly recurring nuisance due to smell and irritation of the eyes, nose, mouth and throat, and aggravation of asthmatic and other respiratory complaints, can prevent a person functioning in society. The potentially ongoing effect of long-term exposure to ETS in children is certainly to be regarded, in the Committee's opinion, as harmful to health. Furthermore, the Committee would not rule out the possibility that long-term exposure to ETS could increase the risk of lung cancer in non-smokers. Some ETS components are carcinogenic in humans and also capable of attacking the genetic material in cells. According to current thinking on carcinogens it is not possible to lay down an absolutely safe level for exposure to ETS.

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APPENDICES

A THE COMMISSIONING LETTER

B THE COMMITTEE

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A THE COMMISSIONING LETTER

In a letter dated 5 April 1989 the State Secretary for Welfare, Health and Cultural Affairs requested the Chairman of the Health Council to make recommendations on passive smoking.

The request was formulated as follows.

The matter is as follows.
The Tobacco Act contains provisions enabling smoking to be banned in public and other buildings. The reason behind this provision is that non-smokers should be protected from the nuisance and possible damage to health caused by passive smoking.
Banning smoking is often the only way of protecting non-smokers, since there is often no other way of preventing involuntary passive smoking as by the use of mechanical ventilation facilities. Research is yielding more and more indications of a connection between the occurrence of a number of disorders and exposure to tobacco smoke indoors, examples being:
(a) lung cancer
(b) respiratory disorders
(c) aggravation of symptoms in chronic non-specific lung disease patients
(d) developmental aberrations in foetuses and children.

In this connection I request the Health Council on behalf of the State Secretaries for Social Affairs and Employment and Housing, Physical Planning and Environmental Protection and myself to advise me on the health risks associated with "passive smoking". I request the Council in so doing to consider existing reports of evaluations such as those of the National Research Council and the Surgeon General in the United States. In particular I should like to receive an answer to the following questions:

1 Can it be concluded from the results of the available research that exposure to tobacco smoke is harmful to the health of non-smokers?

2 If so, is the Health Council able to make an evaluation of the health risks in view of the health principles applied to air quality in the indoor and outdoor environment?

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I look forward to receiving the report of the Health Council as soon as possible, preferably before the end of 1989 in connection with policy-making on the subject.

D.J.D. Dees
State Secretary for Welfare, Health and Cultural Affairs

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B THE COMMITTEE

Membership of Committee
The Committee on Passive Smoking was instituted on 2 February 1989, with the following members.

Chairman
Prof. K.F. Kerrebijn
Sophia Children's Hospital, Dean of Faculty of Medicine and Health Sciences, Erasmus University, Rotterdam

Other members
Dr R.P. Bos
Dept of Toxicology, Catholic University of Nijmegen

Dr B. Brunekreef
Dept of Health, Agricultural University, Wageningen

Dr E. Lebret
Centre of Epidemiology, Environmental Epidemiology Dept, National Institute of Health and Environmental Protection, Bilthoven

F.E. van Leeuwen
Epidemiology Dept, Netherlands Cancer Institute, Amsterdam

Prof. P.H. Quanjer
Dept of Physiology, University of Leiden

Dr G.M.H. Swaen
Dept of Industrial Medicine, Environmental Health and Toxicology, University of Limburg, Maastricht

Advisers
A.P.M. Blom
Air Directorate, Ministry of Housing, Physical Planning and Environmental Protection, Leidschendam

L. van Vliet
Health Directorate, Ministry of Social Affairs and Employment, Voorburg

L. Wever
Alcohol, Drugs and Tobacco Policy Dept, Ministry of

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Welfare, Health and Cultural Affairs, Rijswijk

Secretary
A.E.M. de Hollander
Health Council, The Hague

Administrative assistance was provided by Mrs. M.I. Roskam.

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